The Harvard Pilgrim POS Enrollment/Change Form

GIC

PO BOX 9185 • QUINCY, MA 02269
1-888-333-HPHC
www.harvardpilgrim.org

REASON FOR SUBMISSION (Please check all that apply)

☐ ENROLLMENT
- ☐ NEW HIRE
- ☐ LOSS OF INSURANCE (ATTACH DOCUMENTS)
- ☐ ANNUAL OPEN ENROLLMENT
- ☐ COBRA
- ☐ P/T TO F/T DATE _____
- ☐ OTHER _____

☐ CHANGE
- ☐ CHANGE COVERAGE TYPE
- ☐ ADD DEPENDENT LISTED BELOW
- ☐ TERMINATE DEPENDENT LISTED BELOW
- ☐ NAME/ADDRESS CHANGE
- ☐ LOSS OF INSURANCE (ATTACH DOCUMENTS
- ☐ MARRIAGE DATE _____
- ☐ OTHER _____

☐ TERMINATION
- ☐ LEFT EMPLOYMENT
- ☐ NO LONGER ELIGIBLE
- ☐ VOLUNTARY CANCELLATION
- ☐ DECEASED DATE _____
- ☐ MOVED FROM SERVICE AREA
- ☐ OTHER _____

CONTRACT / ID NUMBER	GROUP / COMPANY NAME	DATE OF HIRE	DIVISION	EFFECTIVE DATE
H P S				

EMPLOYEE NAME
FIRST **MIDDLE** **LAST**

ADDRESS
APT. NO. STREET PO BOX

CITY STATE ZIP COUNTY

TELEPHONE (HOME) ( )

TELEPHONE (WORK) ( )

TYPE OF COVERAGE
☐ INDIVIDUAL ☐ 2-PERSON (Only where offered)
☐ FAMILY ☐ OTHER _____

PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK

02 SPOUSE 03 UNMARRIED CHILD UNDER 19 04 UNMARRIED STEPCHILD UNDER 19
05 * UNMARRIED FULL-TIME STUDENT OVER AGE 19 06 HANDICAPPED (VERIFICATION REQUIRED) 07 EX-SPOUSE

IT IS VERY IMPORTANT THAT EACH MEMBER SELECT A PRIMARY CARE PHYSICIAN.
AS A PLAN MEMBER YOU MUST CHOOSE A PRIMARY CARE PHYSICIAN (PCP). IF YOU DO NOT HAVE A PCP, NON-EMERGENCY AND MOST SPECIALTY CARE MAY NOT BE COVERED.

FIRST MI LAST (IF NOT SAME AS EMPLOYEE)	LANGUAGE CODE	DATE OF BIRTH MO DAY YR	SEX	RELATION CODE	SOCIAL SECURITY NUMBER	SELECT A PRIMARY CARE PHYSICIAN AND TOWN FOR EACH MEMBER	ARE YOU A REGULAR PATIENT OF THIS DOCTOR?	PCP#
EMPLOYEE		- -	M F	01	- -		Y N	
SPOUSE		- -	M F		- -		Y N	
DEPENDENT		- -	M F		- -		Y N	
DEPENDENT		- -	M F		- -		Y N	
DEPENDENT		- -	M F		- -		Y N	
DEPENDENT		- -	M F		- -		Y N	

LANGUAGE CODES (Optional)

WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? PLEASE LIST THE APPROPRIATE CODE AFTER EACH MEMBER'S NAME. THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.

AS American Sign Language; CA Cantonese; CV Cape Verdean; EN English; FR French; HA Haitian; HM Hmong; IT Italian; KH Khmer; LO Laotian; MN Mandarin; PT Portuguese; RU Russian; SP Spanish; VI Vietnamese; OTHER ☐ _____ Specify

*** IF YOU HAVE LISTED A FULL-TIME STUDENT(S) OVER AGE 19 BUT UNDER THE MAXIMUM STUDENT AGE,** SUPPLY THE FOLLOWING INFORMATION:

STUDENT(S) NAME **NAME OF SCHOOL(S)**

_____

_____

_____

THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY

HAVE YOU EVER BEEN A MEMBER OF *Pilgrim Health Care,* Harvard Community Health Plan, HCHP OF NE, HPHC OR HPHC OF NE? ☐ YES ☐ NO

IF YOU WOULD LIKE TO RECEIVE A MENU OF ELECTRONIC WAYS TO INTERACT WITH US, LIST YOUR E-MAIL ADDRESS HERE.

E-MAIL ADDRESS: _____ (OPTIONAL)

YOUR E-MAIL ADDRESS WILL BE STORED IN A PROTECTED DATABASE AND WILL REMAIN CONFIDENTIAL.

MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY THE PLAN. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN A SEPARATE DOCUMENT. FOR AN EXPLANATION OF HOW HARVARD PILGRIM MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES PROVIDED TO YOU BY HARVARD PILGRIM IN YOUR ENROLLMENT KIT.
MAINE MEMBERS: PLEASE NOTE THAT THE SUBROGATION PROVISION APPLICABLE TO MAINE MEMBERS, OUTLINED IN A SEPARATE DOCUMENT, PERMITS SUBROGATION PAYMENTS ON A JUST AND EQUITABLE BASIS.
NEW HAMPSHIRE MEMBERS: PLEASE NOTE THAN AN ENROLLED PARTICIPANT SHALL BE ALLOWED A GRACE PERIOD OF TEN (10) DAYS FOR MAKING ANY PAYMENT DUE UNDER CONTRACT (N.H. RSA 420-B:8(IV)(b).I UNDERSTAND THAT A COPY OF THIS FORM WILL BE GIVEN TO ME , OR MY AUTHORIZED REPRESENTATIVE, UPON REQUEST.

ACTIVE EMPLOYEES: Please return this form to the GIC Coordinator. **RETIREES:** Please return this form directly to Harvard Pilgrim at the address above.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

THE EMPLOYEE, SPOUSE AND ALL DEPENDENTS AGE 18 YEARS AND OVER MUST SIGN THIS FORM FOR ENROLLMENT.

EMPLOYEE SIGNATURE _____ DATE _____ DEPENDENT SIGNATURE (age 18 years - over) _____ DATE _____ DEPENDENT SIGNATURE (age 18 years - over) _____ DATE _____

SPOUSE SIGNATURE (if applicable) _____ DATE _____ DEPENDENT SIGNATURE (age 18 years - over) _____ DATE _____ EMPLOYER SIGNATURE _____ DATE _____